Mental Health in Schools: Toward A Shared Agenda

ABILENE PLANNING TEAM

"He who has health has hope; he who has hope has everything."
Arabian Proverb

I. Plan Introduction

History of Collaboration:

1. Betty Hardwick Center (MHMR) teamed up with the Mental Health Association in Abilene to provide Mental Health CPR (suicide prevention) to fifth, seventh and ninth graders in schools in Taylor, Jones and Callahan Counties – 1992-1999.

2. Mental Health Association in Abilene provided Prevention of Family Violence training to students in Taylor, Jones and Callahan counties – 1999-2001.

3. MHMR provided Self-Esteem training to fifth and seventh graders in Jones and Callahan counties – 1987 – 1992.

4. For many years the Regional Crime Victim Crisis Center has provided age appropriate anti-victimization training to students in K-12th grades. Elementary students receive WHO © (We Help Ourselves) training. Middle school and high school students receive training in Date Rape and Sexual Assault Prevention.

5. MHMR published and distributed 20,000 copies of ***Be Happy Attitudes***, a coloring book of good mental health tips, to elementary schools in Taylor, Jones and Callahan counties in 1990.

6. MHMR includes public school teachers, counselors, principals and superintendents in many events and activities, such as: Legislative Forums, Public Forums, Appreciation Lunches, Self-Advocacy Workshops, etc. School personnel also serve on various MHMR committees and boards.

Operational Initiatives:

1. ARCADA (Abilene Regional Council on Alcohol & Drug Abuse)– provides educational information through classes to every campus in the Abilene Independent School District for grades fourth, seventh and high school.

2. Serenity House (local inpatient substance abuse facility) – provides substance abuse education services to seventh grade health classes for 6 weeks on MH and drug and alcohol issues.

3. Suicide prevention through AISD Counselor's office – five sessions of individual counseling paid for through the district for counseling in the community.

4. Betty Hardwick Center (MHMR) – local crisis intervention authority provides emergency on site evaluations.

5. AISD Student Assistant Services staff that deal with mental health issues on campuses. Services are limited though due to caseload size and administrative responsibilities (SAT preparation, Career counseling, college preparation, etc.)

6. CRCG (Community Resource Coordination Group) – referral source.

7. Juvenile Probation – has the authority to mandate MH services.

8. Parenting classes for unwed parents (Parenting Place).

9. Community in Schools – Abilene High, Cooper, PASS – at least 200 kids.

10. Safe and Drug Free Schools funds help pay for some counseling for students.

Family Involvement:

1. Limited from MHMR perspective due to poor responses on recent surveys, participation in open houses, etc.

2. Houston Student Achievement Center – negative responses from families.

3. Parenting Place (local grant funded parent, child and family organization. Provides classes to parents and families as listed below.) – somewhat successful, 90% retention rate, 4000 served last year, 1800 recipients of their monthly newsletter, some are mandated to attend classes.
   -provides prenatal care, parenting classes, "Tired of Yelling" classes, "Effective Parenting for Teens", "Raising Children with ADHD", Life Skills Training.
   -have had problems with getting schools to let them provide training to parents on campus: this is changing.

4. AISD Counseling – limited involvement from parents on High School level, better for Junior High.

Positive Aspects:

1. Willingness of agencies to work together to benefit the mental health of children.

2. Willingness of agencies to share resources; i.e., meeting rooms, copiers, paper products, etc.

3. Rapid concurrence of team members in identifying initial target group.

4. Identifying a goal that can be measured for outcomes in a reasonable amount of time (short-term).

5. Community-wide interest in improving the quality of life for children.

6. Local foundations with interests in children that could be sources for grant monies.

7. Potential assistance from pharmaceutical companies to provide sample medications for children with mental health needs.

Gaps in School-Based Mental Health Care:

1. Due to caseload size and other duties, actual counseling in schools is limited. There is a great need for more one-on-one intensive therapy.

2. Insufficient MHMR funding to serve children and adolescents with mental health issues. According to the 2000 census, there are 173,221 people residing in Taylor, Jones, Callahan, Shackelford & Stephens Counties. Using statistics provided by TDMHMR, there should be about 3,020 children and adolescents who have mental health needs. Of that number, about 230 would meet priority population as defined by TDMHMR. So, we are serving 95 of 230, and the remaining are getting help wherever they can, or not at all.

3. Teachers and counselors readily identify children and adolescents with mental health needs, but there are limited services to refer them to.

4. Some teachers and/or school nurses are not trained to work with children and adolescents who have mental health problems.

5. Because students who need mental health treatment often cannot get it, safety becomes a big issue for the rest of the students.

6. Many schools have skills training classes, but this measure is less effective with students who cannot focus, concentrate, or comprehend due to their mental or emotional disorders.

7. A large number of children lack parent involvement in their lives. Children learn through the relationships they have, often through a good relationship with a school, teacher or counselor.

8. Our area is in great need of a child psychiatrist. There will not be one available in our area starting August 1st.

9. Limited use of telemedicine due to nonexistent funding to support the service.

Local/Regional Vision:

Our vision is that children and adolescents' mental health services will be a partnership of family members, service providers, school personnel, policy makers, and community members that work as a team to create services that are responsive to individual needs.

We will know that we are approaching our vision when:

- Children and adolescents with mental health needs lead secure, productive and satisfying lives at school, at home, and in the community.

- Children, adolescents and their families report they are pleased with the quality and availability of mental health services, and are actively involved in helping design the services.

- Relationships with families, service providers, school personnel, policy makers and other community members are open and mutually supportive of the mental health of children and adolescents.

- That all students and school personnel enjoy coming to school because they feel safe and valued.

I. Action Initiatives

1. Local/Regional Barriers:
    - Time – Those of us on the Planning Committee are very excited about and interested in getting/having school-based mental health services. However, each of us is employed in jobs that already demand 100% of our time to accomplish our job expectations.
      -possible solution: Utilize resources at universities.

    - Space – In response to declining student populations and school budgets in our area, schools are closing. To accommodate students from school closures, remaining campuses will become more crowded. We will be challenged to find the space needed to provide mental health services on each campus.
      -possible solution: Use space in closed schools.

    - Funding – It is unlikely the State will provide funds for mental health services in schools. There is very little, if any, flexibility in state funds, whether MHMR or public school, to use on such a project as this. Historically, the State of Texas provides mental health funds for treatment of serious and persistent mental illnesses, and not enough to serve all who need it.
      -possible solution: We can probably get grants from foundations to cover expenses for a limited period of time. If we rely on grant money, we may start a program one year, and have to close it the next. Mental health services in schools are an ongoing need that needs ongoing funds.

- Large area to cover – Region 14 Education Service Center is comprised of 43 school districts. Abilene is the largest city in the region, and provides employment opportunities for a large rural area. Children and adolescents in rural schools who need mental health services are much less likely to get the services they need, because their parents work in Abilene and do not have the time away from their jobs and/or means of transportation to pick them up from school and drive them back into Abilene for mental health services. Many rural students ride school buses to and from school, and don't see their parents from 7:00 a.m. until 7:00 p.m. For these students to receive the mental health services they need, the services need to be provided on school campuses.
  -possible solution: Continued collaboration amongst participating agencies to combine coverage alternatives.

- School counselors not MH providers - Most school counselors spend their time doing academic counseling, not mental health counseling. Every school campus should have one mental health counselor for every 500 students. If one in five students have a mental health issue, counselors would average a caseload of 100 students at any given time.
  -possible solution: Utilize graduate students at local universities to provide needed counseling.

- Transportation issues – Frequently, students who are most in need of mental health services come from a lower socio-economic status. It is vital that these students receive the mental health services they need while they are on the school campus. It's highly unlikely that a parent or parents will take the child to another site to receive mental health services. In rural schools, most students ride a bus to school. In rare instances, their parents may not even own a car, and have to rely on other family members or friends to drive them places.
  -possible solution: Continued collaboration amongst participating agencies to combine transportation alternatives.

- Communication between those providing community services – Abilene agencies try very hard to share information with each other that will result in improving customer services. One such group is called FRIENDS. This group, which is comprised of 40-plus agencies, has been meeting since 1997. Some of the primary purposes of FRIENDS are:
  - ☺ to share information about service eligibility,
  - ☺ identify duplication of services,
  - ☺ seek ways of serving unmet needs,
  - ☺ advocate for consumers,
  - ☺ help develop public policy by working with Legislators.

One of the challenges of local human service agencies is employee turnover. Human service positions in the Abilene area pay less than similar jobs in large cities. There are three religious based universities in Abilene, so it is common for area agencies to hire recent college graduates.

However, after gaining basic experience with a year or two of employment, these folks will move out-of-town into jobs of higher pay and better benefits.

2. Action Initiatives to increase the Resource Base:
   - We will seek grants from foundations (Dodge-Jones, etc).
   - We will provide public education to promote community awareness of the need for mental health services in schools, and perhaps find additional donors.
   - We will analyze the budgets of participating agencies to uncover any funds that can be appropriately applied to mental health services in schools.

3. Local Regional Action Initiatives to ensure Access:
   -Need a child psychiatrist – we will seek to involve city and county officials in helping to attract a child psychiatrist to the Abilene area. Should funds become available for telemedicine, we will look into procuring (a) contract(s) with child psychiatrists in larger urban areas.

   -Encourage rural ISDs to utilize Special Education funds to bring therapists to the school campuses.

4. State Policy, Funding, and Legislative Barriers:
   -Telemedicine funding
   - Historical under-funding of mental health services. Texas ranks 46th in the nation for per capita funding of mental health services.

5. Strategies to increase and improve Family/Youth Knowledge:
   -Distributing brochures, do public service announcements on television and radio, ads in local papers, internet web site information, etc.
   -Collaboration through Parenting Place, parent education, on-campus meetings, conferences, etc.

II. Near Term Changes: Goals and Strategies (Action Initiatives) for Local/Regional Implementation

1. Build a partnership to search for a prospective child psychiatrist. We would need to consider options for travel, telemedicine, funding to support it, etc.

   A. Identify stakeholders to provide support through a partnership to search for a child psychiatrist. (Within one month of plan implementation)
   B. Provide continued support for elected officials in implementing financial funding for telemedicine. (Immediate, ongoing)
   C. Build a philosophy statement supporting telemedicine and its benefits, especially for rural communities. (Within two months of plan implementation)

2. Education to parents on mental health issues on and off school campuses.

   A. Seek out the support from the Abilene Independent School District Superintendent and School Board to provide mental health awareness on campuses. (Within three months of plan implementation)
   B. Collaborate with Parent Teacher Associations and Parent Coordinators to provide mental health awareness in their meetings and through other avenues. (Within three months of plan implementation)
   C. Create and distribute behavioral health literature through homeroom teachers. (Within four months of plan implementation)

3. Identify target population of students and implement mental health counseling services on school campuses.

   A. Seek out the support from the Abilene Independent School District Superintendent and School Board to provide mental health counseling on campuses. (6 months)
   B. Contact local universities to collaborate with on counseling project. (6 months)
   C. Obtain parental permission to provide mental health counseling to students on the school campus. (6 months)
   D. Establish guidelines of project: (6 months)
      a. Identify 3 groups of 4^{th} – 6^{th} grade students through assessment, including identification of appropriate diagnosis - (severe, moderate, control)
      b. Total of 60 students on three campuses
   E. Provide appropriate type of counseling (Individual, Group, Cognitive-Behavioral Therapy, etc.) through a local university's marriage and family therapy program for a pre-established amount of time (within 6 months of identification)
   F. Perform a post-evaluation of students to see results of project (at the end of 6 months of counseling)
   G. Report results back to the ISD, TDMHMR, TEA, parents and other necessary groups. (within one month of post-evaluation)
   H. Discuss with ISD and universities the possibility of an ongoing longitudinal project. (at the end of the project)

III. Long-Term Improvements: Goals and Strategies (Action Initiatives) for Local/Regional Implementation

1. Reduced Recidivism in school and community

   A. School – stability, better attendance, improvement in grades, improved relations ship with teachers.

1. Distribute a Parent Questionnaire to get feedback on any changes in behavior from the Pilot Program in the schools. (within 6 weeks after the end of the Pilot Program)
2. Distribute a Teacher Questionnaire to get feedback from teaching staff regarding the Pilot Program. (within 6 weeks after the end of the Pilot Program)
3. Distribute a Student Questionnaire to get feedback regarding any changes they saw in themselves as a result of the Pilot Program. (within 6 weeks after the end of the Pilot Program)
4. Provide a Parent Questionnaire to ALL parents on the effectiveness of the educational materials provided to them regarding mental health issues in children that was distributed (See #2 in Near Term Changes, pg. 8). (within 6 months after the materials were distributed)
5. Track statistics such as attendance, classroom points sheets, token system, etc. to determine effectiveness of program. (within 6 weeks after the end of the Pilot Program)
6. Consider the possibility of a longitudinal Pilot Program to study long-term effects. (after the results of the questionnaires are received and studied)
7. Provide Mental Health services as appropriate for those students identified with such issues. (as needed)
8. Provide easy access to mental health referral systems to treat mental health issues early. (as needed)
9. Provide coaching for parents through the Parents Place, as appropriate. (as needed)
10. Seek out retention incentives for a child psychiatrist to continue psychiatric medication and evaluation services. (within 6 months of acquiring the services of a psychiatrist)

B. Community – acquiring skills to not be a drain on society, lead a productive and responsible life.

1. Refer to student/parent Pilot Program questionnaire for statistics to determine the effectiveness of the program. (within 6 weeks after the results of the questionnaires are received and studied)
2. Track Juvenile Justice System with Pilot Program results to determine if there are any significant changes in the recidivism rate. (after the results of the questionnaires are received and studied)
3. Provide referrals to community resources for parents to teach their children to become responsible adults, role modeling, coaching, mentoring, etc. (as needed)
4. Track access of community resources for assistance. (as needed)

Appendix A

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Laurie Stevens-Beck, Harmony Family Services

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Angie Penton, Harmony Family Services

Robbye Plummer, Betty Hardwick Center

Priscilla Rayford, Parent

Appendix B

Our Regional Team met a total of 6 times over the course of four months in several different locations, such as the Region 14 Education Service Center, The Parenting Place, and the Betty Hardwick Center. We met in groups of up to 12 and as few as 6. The meetings were kept very informal and usually lasted 1½ hours.

We did not have a formal secretary to take notes; we all did this to an extent. We typically added information to our plan as we went along through the meetings.

In regards to voting, this was kept somewhat informal as well. When a suggestion was brought up by one or more of the group members, the group would discuss it. Once it was fully understood, we would write the comment or suggestion down and make it a part of the plan. As time went on, time was less and less available for meetings, so we did some discussion and communicating via email.

On occasion, a subject was brought up that no one in the group knew the answer to, so we would make assignments to have one of the group members seek out the answers and report it back to the group, either at the next meeting or by email. Once the answer was found, it would be added to the plan.

Appendix C

Outcomes identified by:

Education –

AISD would probably like to see movement towards a system to identify, evaluate, and treat children with severe mental health issues. Specifically, treatment for cases of extreme depression, bi-polar, and even childhood schizophrenia that prohibit the student from having any "real" opportunity to succeed in the public school setting would be in order. Identification of these cases in elementary or early middle school would provide the best opportunity for success, rather than during more turbulent high school years.

It would appear that the most "effective" means would be to establish a superior net to catch such children. Instead of making drastic changes in any agency, it would seem that a collaboration between AISD, Betty Hardwick Center, Abilene Psychiatric Center, the local hospitals, etc., to develop a process for our existing counselors/teachers to use when these conditions are suspected would be the most efficient way to approach the situation. (Perhaps a good screening instrument for our elementary and middle school counselors would be in order here.) Having a referral base comprised of agencies with numerous funding sources would follow through with treatment, both in and out of school settings. There are numerous agencies and school personnel that bend over backwards for kids. The Special Education department handles many more of these students than most people are aware. A more consistent, systematic, effective network that did not get bogged down with paperwork, self-serving agendas, etc., would give school personnel someone to work with, and vice-versa.

This push by the government may be a way to build on what we already have, and secure funding to treat a special population of youngsters before it is too late. It would appear that due to the huge number of students in the region, a mental health initiative should address mental health situations that are creating disabilities for life. Our initiative would have a targeted agenda for a group of the most seriously ill. We would promote and encourage other programs to address other essential mental health issues such as mentoring, prevention, parenting, etc., to the remaining students.

Mental Health –

Mentoring programs in the school from outside resources such as volunteers, Mental Health Association, church organizations and other non-profit agencies.
Getting more counselors on campus to deal with past and current issues, so as to prevent future behaviors.

Obtaining the services of a Child Psychiatrist for our area is critical. Counseling and rehabilitative services will only go so far without the control of correct medication.
More parent awareness involvement in the mental health issues of their child, on and off the school campus. More funding to provide mental health services in our area.

Youth –

-Identify behaviors for treatment.

-Early intervention is key to decreasing services needed as an adult, and less expensive on society in the long run.

Family Members –

If we can get the school-based service established with a more combined effort, then it will be possible to move beyond basic MH care to help the children with more need. Helping at a young age, when the child is willing & there is more help available, is key to preventing deterioration into a self-destructive teen or barely functioning adult with more severe symptoms.

The more we can combine services delivery places & move them closer to home the better life will be for the child & the parent. It can be a vicious or blessed circle. When life improves or declines for one, it also affects the other.